Medical Associates of Georgia, Inc.

3584 OLD MILTON PKWY
ALPHARETTA, GA 30005
PHONE: 678-691-3388
FAX: 678-395-7702
www.medassocga.com

PATIENT INFORMATION

MRN:

NAME: _____ _____ _____ AGE: _____ **F** or **M**
LAST FIRST MIDDLE

DOB: _____ SSN: _____-_____-_____ **Single Married Divorced Widowed Other**

ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP

PHONE: _____ _____ _____
HOME WORK CELL/PAGER

PHARMACY: _____ E-MAIL: _____

EMERGENCY CONTACT (MUST BE RESPONSIBLE PARTY IF PATIENT IS A MINOR)

NAME: _____ _____ _____ DOB: _____
LAST FIRST MIDDLE

ADDRESS: _____ _____ _____ _____
STREET (IF DIFFERENT FROM ABOVE) CITY STATE ZIP

PHONE: _____ _____ _____
HOME WORK CELL/PAGER

RELATION TO PATIENT:

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ GROUP #: _____

INSURED NAME: _____ DOB: _____ RELATION TO PATIENT: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____

INSURED NAME: _____ DOB: _____ RELATION TO PATIENT: _____

ETHNICITY ☐**Hispanic or Latino** ☐**Not Hispanic or Latino**

RACE ☐ **American Indian or Alaska Native** ☐**Asian** ☐**Black or African American** ☐**Hispanic or Latino** ☐**Pacific Islander** ☐**White** ☐**Other**

PREFERRED LANGUAGE ☐ English ☐Spanish ☐Russian ☐Indian (includes Hindi & Tamil) ☐Other

REFERRAL SOURCE ☐Drive by ☐Internet ☐Phone Book ☐Referral by _____

_____ _____
Signature of Person Filling out Form Date

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Patient Health History

Patient's Name _____ Date of Birth _____ MR# _____

Please answer 'Yes' or 'No' to the following Health History questions, and elaborate if needed.
Your answers are for Medical Associates of Georgia's records only and considered confidential.

Medical History

Allergies ……... Yes [] No []
Anemia ……. Yes [] No []
Arthritis …… Yes [] No []
Asthma ……. Yes [] No []
Bone Fractures ……. Yes [] No []
Cancer …….. Yes [] No []
Chemotherapy…… Yes [] No []
Chest Pain ……. Yes [] No []
Chronic Pulmonary Disease…….. Yes [] No []
Depression……..Yes [] No []
Diabetes……..... Yes [] No []
Dizziness/Fainting……. Yes [] No []
Epilepsy or Seizures…….. Yes [] No []
Frequent Headaches…….. Yes [] No []
Gall Bladder Disease……. Yes [] No []
Glaucoma or Cataracts ……. Yes [] No []
Hearing Disorder……... Yes [] No []
Heart Disease……. Yes [] No []
Heart Murmur…… Yes [] No []
Hemophilia (Bleeding Disorder) ….. Yes [] No []
Hepatitis……. Yes [] No []
High Blood Pressure…….. Yes [] No []
High Cholesterol …….. Yes [] No []
Insertion of Pacemaker …… Yes [] No []
Kidney or Bladder Disease …….. Yes [] No []
Liver Disease …… Yes [] No []
Memory Loss …… Yes [] No []
Menstrual Dysfunction ……. Yes [] No []
Mental Illness ……... Yes [] No []
Rheumatic Fever …….. Yes [] No []
Scarlet Fever ……. Yes [] No []
Sexual Dysfunction……... Yes [] No []
Sexually Transmitted Diseases…….. Yes [] No []
Stroke……..... Yes [] No []
Thyroid Disease……. Yes [] No []
Tuberculosis…….. Yes [] No []
Ulcers (stomach) ……... Yes [] No []
Women: Are You Pregnant? ……Yes [] No []
Date of LMP? _____
Are you taking birth control? .....…... Yes [] No []
# of Pregnancies_____ # of Live Births _____
# of Miscarriages_____
Have you gone through Menopause? Yes [] No []

Have you ever had **Surgery** of any type? ……. Yes [] No [] ****PLEASE LIST TYPE AND YEAR****

_____
_____

Medications

Are you taking any Medications, Vitamins or Supplements? If so please list below:

_____
_____
_____
_____
_____
_____
_____
_____

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Are you **Allergic** to or have you reacted adversely to:
Local Anesthetics ……. Yes [] No []
Penicillin …….. Yes [] No []
Other Antibiotics ……. Yes [] No [] NAME: _____
Latex …… Yes [] No []
Foods …… Yes [] No []

Other Allergies: _____

Social History
Do you Smoke ……...Yes [] No [] # of Years _____ Packs per day _____
Quit when? _____
Do you dip Snuff? ……..... Yes [] No [] How much? _____ How often? _____
Quit when? _____
Do you drink Alcohol? ……..Yes [] No [] How much? _____ How often? _____
Do you use street Drugs? …….. Yes [] No [] Type _____
Have you ever tested positive for HIV/AIDS? …… Yes [] No []

Have you ever required a blood Transfusion? ……...Yes [] No [] If so, explain the circumstances: _____

Family History: List any family (blood relative) that had the following:
Example : Heart Disease … Yes [X] No [] father, uncle, pat grandfather

Heart Disease ……	Yes [] No []	_____	Cancer …….…….…	Yes [] No []	_____
Depression ……	Yes [] No []	_____	Tuberculosis ……	Yes [] No []	_____
Diabetes ……	Yes [] No []	_____	Stroke ……..……	Yes [] No []	_____
Glaucoma ……	Yes [] No []	_____	Alcoholism ..……	Yes [] No []	_____
High Blood Pressure ……	Yes [] No []	_____	Mental Illness ..……	Yes [] No []	_____
High Cholesterol …….	Yes [] No []	_____			

Do you have any disease, condition or problem Not listed above that you think I should know about? …. Yes [] No []
_____
_____
_____
_____
_____
_____
_____
_____

The information that I have provided above is true and correct to the best of my knowledge.

_____
Patient, Parent or Guardian's Signature Date

_____
Your Name (Please Print) MR#

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DISCLOSURE OF HEALTH CARE INFORMATION NOTICE

I understand that as part of my healthcare, Medical Associates of Georgia, Inc. originates and maintains paper and/or electronic records describing my demographic information as well as records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information may serve as:

- ✓ A basis for planning my care and treatment.
- ✓ A means of communication among the many health professionals who may contribute to my care.
- ✓ Information for applying my diagnosis and surgical information.
- ✓ A means by which a third-party payer can verify that services billed were actually provided.
- ✓ A tool for routine healthcare operations such reviewing the competence of healthcare professionals and assisting quality.
- ✓ A means by which to contact me regarding my treatment, follow-up, and various test results.

I understand that I have the following rights and privileges:

- ✓ The right to review the "Notice of Information Practice" prior to signing this consent.
- ✓ The right to object to the use of my healthcare information for directory purposes.
- ✓ The right to request restrictions as to how my healthcare may be used or disclosed to carry out treatment, payment or healthcare operations.
- ✓ The right to revoke any prior consent, as provided in writing, except to the extent that the organization has already taken action.

I understand that Medical Associates of Georgia is not required to agree to the restrictions requested. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Medical Associates of Georgia reserves the right to change their notice of privacy practices. I will be notified of the changes in writing, upon my next visit.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

In the event Medical Associates of Georgia refers me to a SPECIALIST, I hereby authorize Medical Associates of Georgia to release my medical records to the SPECIALIST and also to authorize the SPECIALIST to release my medical records and SPECIALIST REPORTS back to Medical Associates of Georgia.

I wish to implement the following limitations or allowances regarding the use or disclosure of my healthcare information:

_____

_____

I fully understand and ❑ ACCEPT ❑ DECLINE the terms of this consent. (Please check one)

_____ _____

Patient or Guardian Signature Date

FOR OFFICE USE ONLY:

- ❑ Consent received by: _____
- ❑ Consent refused by patient, and treatment refused as permitted
- ❑ Consent added to the patient's medical record on _____

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PAYMENT AND INSURANCE POLICY

Medical Associates of Georgia, Inc requires that all co-payments and/or deductibles are paid in full prior to service. Medical Associates of Georgia will collect the amounts in which we have agreed upon with your Insurance Company. If those amounts are not available, you will be charged our rate and refunded once your insurance company has completely processed the claim. Medical Associates of Georgia will submit the necessary claim forms to your health insurance company for processing. In the event that your insurance company suspends the claim due to information needed from you, you will be responsible for the total bill until you provide that information and the claim is processed. From our experience, we have found that few insurance plans cover the complete cost involved. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating your claims. All charges not covered by your insurance company will be billed to you. Payment will be due upon receipt of statement. All statements not paid will be turned over to a collection agency. Medical Associates of Georgia requires patients without insurance to pay the full charges prior to service. If you are claiming a work-related injury, Medical Associates of Georgia will file your worker's compensation claim once we have received all necessary information such as carrier name, claim address and telephone number, claim reference number, date of injury and authorization of treatment from your employer. Medical Associates of Georgia accepts cash and credit cards as payment.

ASSIGNMENT OF BENEFITS

I hereby authorize all payments for services rendered to dependents or myself, which are payable to me under the terms of my insurance policy, to be paid directly to PrimeCare Medical Center for services provided. I further authorize the release of any necessary information, including medical information form this office, to my insurance carrier. I understand and agree that I am fully financially responsible for charges not paid by my insurance company.

HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have been offered the opportunity to receive a copy of the "Notices of Privacy Practices" that explains when, where, how, and why my confidential health information may be used or disclosed.

CONSENT FOR TREATMENT

I hereby consent, for myself or dependent, to diagnostic and/or therapeutic medical treatment, procedures, photographs, digital, or other images deemed necessary by the physician(s). I acknowledge that there is no guarantee as to the results of procedures and medical treatments performed.

CONSENT TO BE CONTACTED

I hereby consent to allowing, PrimeCare Medical Center or any contracted agencies used, to contact me to discuss information relative to my medical treatment or services in which I have received.

I certify that the information I have provided is true and correct. I am aware that knowingly providing false information regarding my identity, insurance coverage etc. constitutes fraud.

_____ _____

Signature of Patient/ Guardian Date

_____ _____

Name of Patient/ Guardian (Please Print) MRN